Beyond One Hip Fracture at a Time: Rethinking Aging Services

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ABSTRACT. The argument in this article is that the basic conceptual model used in construction of services to older people served well in years past but is now inadequate, descriptively or analytically. An alternative approach to the construction of community-based services is proposed and then examples from the practice of the author and from other communities are described. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2004 by The Haworth Press, Inc. All rights reserved.]

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In this paper, I want to address concerns about system change in the aging network in three steps:

1. First, I want to offer my views on why the basic conceptual model on which we’ve been trying to build senior services for the last thirty years is now inadequate;
2. Then, second, I want to offer an alternative vision of how we should go about constructing community-based services for seniors, a vision that begins with the proposition that the community is the client;
3. And third, I want to very briefly describe some efforts to put this new vision into practice, both through some of the work we are doing in the Aging in Place Initiative, and in other communities taking other approaches.

For the last 20 years, we have been chasing after the ideal long-term care system through a series of experiments supported both by foundations and government. Despite all these efforts, many of which have been at least partially successful on their own terms, the consensus seems to be that we aren’t much closer to solving the overall problems, that the “big picture” is just as cloudy now as it was in the past. I believe that that’s because we are caught in an old-fashioned and outdated construct.

I will describe some of the problems with our current “systems.” But mostly I want to focus on the shape of some possible solutions, because advance in the fields of aging and medicine and the demographic shifts creating unprecedented concentrations of elderly provide an opportunity to reconfigure service systems to better fit today’s older population, and tomorrow’s. I will suggest some principles that should guide the development of new service models. Noticeably absent from this discussion, however, is the subject of financing—how to pay for services. This is deliberate. First, we need to decide what is needed, by whom, and when they need it. If we start with financing—and try to tweak and supplement the current system, I do not believe that we will then get to where we programmatically need to go.

**ONE HIP FRACTURE AT A TIME**

Designed at a different time, Medicare, Medicaid, and the Older Americans Act are the foundations for the myriad programs and ser-
vices that have developed over the years to meet the needs of a growing and changing older population. These public programs were enormously successful in addressing the problems of their era—providing health insurance to almost all seniors, health care and nursing home coverage for those unable to pay for it themselves, and a nutritious meal in a social setting for the numerous seniors who were malnourished (literally starving to death)—thus contributing to the dramatic increase in longevity and reduction in disability over the last 35 years.

But these programs were formulated in a different time, with different conceptions and problems of aging. I believe that the assumptions on which they were founded are limiting policy discussions about how to respond to today’s issues. We react to each new issue or problem by looking to the structure of one of these three programs to legislate or construct a new coverage policy or service response with the limited dollars available. Our most recent example is the Family Caregivers Support Program, the latest addition to the Older Americans Act. Each add-on has its own sets of complex rules, target populations, limits or regulations that providers and consumers must learn to navigate.

Medicare, Medicaid, and the Older Americans Act have a number of characteristics in common that define who gets what services, when, and for how long. Each is targeted to a subset of the older population. To qualify for Medicare, the older person must have a covered medical or skilled care need which requires a specific intervention for a limited period of time. For the long-term care or medical services covered by Medicaid, the applicant must be poor and able to prove his/her poverty going back a number of years before he/she can qualify. The basic services of the Older Americans Act are for those older people in need of a “bare bones” budget and a hot meal to be eaten while “socializing” in the echoing caverns of cement-block senior centers or alone in their own homes if they are homebound. If the individual does not fit one of these categories based on service type or income, he/she probably won’t get what is needed. Often, access to a service under these three programs is triggered by a medical event that brings the older person into contact with a health or social services professional. The dreaded “fall” is usually the event that starts the access to services.

A case in point is Mrs. Smith, who is 77 years old and lives alone. She suffers a fall, breaks her hip, and is hospitalized. During her stay it is discovered that her thyroid level is dangerously low. She is discharged home with Medicare-covered intermittent home care and Meals on Wheels from her local senior center so that she will have a hot meal on the days the home health aide does not come.
Before the fall, Mrs. Smith had been a regular at her local senior center, but eight months earlier, had stopped going due to increasing confusion. Mrs. Smith had no idea that she was having a thyroid problem. She just hoped nobody else saw that she was having a hard time keeping it together. She did not want to go to a nursing home or have a stranger in her house taking care of her. The center staff had called her a few times to encourage her to return, but did not succeed in their mission. Six weeks after she left the hospital, Mrs. Smith was discharged from Medicare home care, but the meals continued. After being discharged from home care, she still had difficulty ambulating which made it hard to get to the drug store to fill her thyroid prescription, which led to further confusion and decline. Six months later, after a fall and another hospitalization, Mrs. Smith had become a daily Medicaid home attendant client.

Our three major systems are designed to react to these kinds of events after the fact. Most of the time, they also require the older person to self-identify. The client needs to be aware that there is something wrong, and must also be willing to reveal that to strangers at exactly the time she may feel most vulnerable to the loss of independence. One other point should be made about the experiences of this client: In the definition of her problem, the responses by service providers, the determination of eligibility for services, and the actual provision of services, she and all her providers could have been living on Mars. They provide the appropriate, contracted service, but there is no connectedness to the community or web of social networks in which Mrs. Smith lives. Each provider acts as an autonomous entity. Even those providers that describe themselves as community based may be located in the community, but aren’t really connected to the life of the community. Again, these problems arise from what is fundamentally a desirable characteristic of the design of the three 60s programs—their universality and uniformity of benefits: Eligibility for specific benefits is supposed to be unrelated to where one lives or what services are most available in a specific community. But we know that with the exception of a relatively small number of seniors whose social isolation is extreme, most older people live within a web of community, family, and social networks and are supported by and provide support to others within these networks. Understanding that context is often critical to a complete assessment of a client. Mobilizing at least part of those networks is often essential to delivering the kinds of services the client needs.

Further, our emphasis in the last two decades on providing long-term care services at home or in the community, in contrast to nursing homes
or other institutions, may have had the ironic effect of further disconnecting frail seniors from community networks. As an eligibility criterion, the status of “homebound” may become self-reinforcing. One older person eloquently described her fear of becoming “entombed” in her apartment as the services she might need for a specific event serve to keep her locked behind her apartment door, separated from the community in which she lives.

AGING ISN’T WHAT IT USED TO BE

While our major public programs may not have changed sufficiently to meet the needs of a changing elderly population, our understanding of the characteristics and needs of the elderly has increased enormously in recent years. To begin with, we understand that the elderly population is increasingly heterogeneous on every relevant dimension. Aging is not a process of linear decline; in fact, not all the elderly decline in any measurable function at all. For those with chronic illnesses, even serious chronic illnesses, there is considerable oscillation back and forth in health status. As new treatments emerge, the serious disabling effects of some of these chronic illnesses are also decreasing. We increasingly understand that healthy aging is possible and that it can be encouraged and supported through specific health promotion and prevention interventions. While we have become increasingly proficient at some event-based interventions, such as elective hip replacements, we also increasingly understand that such interventions are only a small part of the total equation of a person’s well-being.

Several recent studies have shown that isolation from active, effective social connectedness is a significant mortality risk factor—even more important than smoking. Tom Glass of the Harvard School of Public Health reported in 1999 that engagement in social activity was as beneficial as physical activity in reducing mortality in seniors. But social activity for its own sake—just to keep busy—has its limits. Mastery over one’s life or being able to influence what happens was the strongest predictor of maintenance of cognitive functioning in basically healthy 70- to 79-year-olds who were followed for eight years by a MacArthur Foundation study. Continuing to grow and learn new things, maintaining social connectedness, and remaining a vital and involved person in the world and community turn out to be you are as important to an older person’s health as the public programs designed to treat specific diseases or events.
Our current categorical, event-based systems have no way of incorporating this connection into their existing individual needs-based framework. So we have looked outside these systems to create opportunities for active, fully mobile seniors to engage in meaningful activities: college courses for free or reduced rates; artistic endeavors; Elderhostel vacations to learn while one travels; mentoring to younger professionals in one’s field, and other volunteer opportunities are targeted to that subset of seniors who are self-starters, most likely well-educated and economically secure, and able to freely and easily get around. We’ve all heard stories about how hard it is to get in touch with some of our older friends because they’re never home.

However, the moment an illness or disease process slows an older person down, these roles, relationships, and activities do not continue for very long, if at all. The ability or desire to engage in meaningful or creative activity often remains, but the pace and ability to travel any real distances diminishes. The immediate community in which one lives becomes a larger and larger focal point of one’s daily life as one ages in place. How well communities are able to absorb these changing roles and take advantage of these potential resources is something that we need to understand better.

**GEOGRAPHIC CONCENTRATIONS**

The demographic changes we have experienced, and will continue to experience for years to come, are producing some significant changes in the make-up of our communities. Never before in this country’s history have so many older people constituted such large numbers of the residents of so many communities. With the percentage of people over the age of 65 expected to reach 20% of the population by the year 2030, concentrations of seniors will be found in most age-integrated communities across the country. Older peoples’ housing patterns have not changed very much over the last 25 years and even with the flurry of activity around assisted living facilities, planners do not expect major shifts in the future. As AARP’s surveys have consistently shown over the last 15 or so years, the overwhelming majority of seniors prefer to remain in their own homes. There will always be some small subset who prefer or must live in senior-specific facilities, but the bulk of America’s older population will continue to live where they are right now—in even larger numbers and proportions.
Common to many of these communities is the heterogeneity of their older residents. Be they single family home ownership communities, large private or public apartment complexes, Section 202 Senior Housing buildings, garden apartment developments, or even assisted living facilities, their seniors, old and young, rich and poor, have constant back-and-forth changes in health status; possess a wide range of interests, skills, and talents; and have changing needs over time. Geographic concentrations of seniors give us the opportunity to reconfigure the service system in ways that fit better with our understanding of aging as a dynamic process and not a one-way downward spiral. It is at the community level that we will need to build the supports and systems necessary to support healthy aging and respond more quickly and effectively to the changes the elderly experience.

**PRINCIPLES TO GUIDE US**

We can do this system services building by borrowing from the principles of population-based public health and public administration’s district organization of human services. By looking statistically or epidemiologically at the health (broadly defined) of a community and then narrowing our focus to specific community characteristics, we can identify priorities, engage in proactive case finding, and employ a range of preventive strategies at the community level as well as specific interventions targeted to individuals. The services delivered thus grow out of the characteristics of the residents rather than a predetermined list of benefits. Eligibility is determined by virtue of being a resident of a community rather than by fitting into a categorical box when a crisis hits. In some very real sense, the entire community, not just some of the individuals who reside in it, is the client. For example, a community with a high incidence of falls may need a variety of approaches, activities, and interventions to address problems that often have multiple intertwined causes. Individual in-home environmental assessments may do little to mitigate falls due to uneven sidewalks, poorly-lit walkways, or untreated hypertension among community residents not connected to primary care.

The increasing concentrations of seniors provide a natural opportunity to reconstruct our service system in a more sensible way that recognizes the heterogeneity of older people’s needs and interests and the changes over time. Let me suggest some principles to guide us:
• New service delivery models should be community derived;
• Eligibility should be defined by residence and age;
• Services should be designed to build on the strengths of the community and its residents to maximize independence and engage seniors before the point of acute crises; and,
• Services should be staffed by well-trained social work and health professionals who are skilled in assessment and intervention at both the macro and the micro level.

A community-derived model is one that is rooted in and reflects the unique characteristics of the community. To be rooted in the community means more than just being located in a community setting with accountability to some distant parent office. It implies being part of the fabric of the community and, on some level, accountable to it. Each community is unique and made up of distinct population groups. Each has its own history and culture, its own formal governance structure, its own formal and informal social structures and supports, and its own ways of communicating. These are the strengths of a community that, if understood and harnessed, make it possible to connect to the residents, engage them, and develop relevant programs and services that address their needs and interests. For example, understanding how residents get information in a community with high illiteracy rates is critical to developing effective outreach strategies and programs. In such a community, with its dependence on verbal communication, it may be that a system of floor captains needs to be developed to routinely impart information and engage the residents.

For years, providers have been going out to seniors centers or “the community” to market their services through screening or education programs. Those 20 or 30 seniors who attend just happen to have heard about it. Typically, maybe two people are found to have seriously elevated blood pressure readings, or are moderately depressed, or are eligible for QMB/SLMB. At the end of the day, those seniors are told to talk to their doctors or contact a social service agency. The provider goes back to its home base and the event is considered a success. But nothing much changes in the community.

Each community has a unique blend of problems as well as resources available to help solve them. Bringing together the community stakeholders with the professionals accountable to that community permits identification of problems that are beyond one individual and provides a mechanism to develop different kinds of solutions that may be more communal. In a community with increasing numbers of people diag-
nosed with Alzheimer’s or related dementias, do we teach each spouse caregiver how to manage on his or her own, or does the community also find a way to develop an on-site social adult day program, as has happened in a number of communities in New York and elsewhere. In a community of two-family cooperative garden apartments, do we keep sending in a homemaker service to do the shopping and laundry for each older person stuck in an upper-level apartment because they can no longer navigate the stairs, or are there other solutions to this growing community problem? The board of directors of this co-op may decide to look at the feasibility of retro-fitting the stairs or perhaps develop a policy for swapping upper floor apartments for ones at ground level.

Who gets served in a community-derived model? If the goal is to build an environment that recognizes the heterogeneity and changing needs and interests of seniors, then eligibility to participate is determined by one’s residence in that community and not by a functional deficit or health crisis. Participation then starts at the point of program development, by asking the older residents not only about their problems but also what their interests and skills are so that in addition to individual social work and health care management services, educational and recreational activities can be developed that reflect the specific characteristics of a community, and draw on the resources or strengths of its residents to implement. This conveys a very powerful message of ownership to older residents—that they have something to contribute and that they can be productive and effect change.

It is sometimes often amazing what skills one can find in communities—artisans and artists, writers and actors, storytellers and singers, advocates and activists, nurturers, mechanics, cooks, teachers—the list is often limitless, for most older adults have filled many roles during their lifetimes. For example, in New York City there is a community in which a retired statistician guided the design and implementation of a survey of its older residents. And in another neighborhood, a retired social worker used her professional and personal skills and experience in helping so many older neighbors trying to take care of their grandchildren that she organized a grandparents support group. And she has had the satisfaction of seeing her work become a model for other communities. It is the life experiences of the older residents themselves that are valued and help define the program and services delivered.

Community-derived models must have expertise in and utilize the specific tools of Medicare, Medicaid, OAA, and EISEP services to cover or respond to specific medical events or time-limited resource
problems. But just their expertise and program utilization. A service delivery model that focuses only on those seniors who are in crisis runs the risk of stigmatizing the very people it is trying to help. Such a well-meaning model will assess an older person along many dimensions to see if they need or qualify for X, Y or Z entitlements. If they don’t, or if they refuse, they are told to “call us when you need help”–which, in an older person’s mind, can often translate to “when you’ve failed.” In that approach, engaging seniors before a crisis becomes much harder and reengaging them after a crisis, harder still.

Shifting from reactive responses to a proactive service delivery system will require well-trained social work and health professionals who are skilled in assessment and intervention at both the macro (community) and the micro (individual) level. At the individual level, in addition to possessing strong clinical skills and knowledge of the biopsychosocial aspects of aging, social workers and nurses and other professionals must possess an ability to work in interdisciplinary teams to integrate their respective assessments into a comprehensive understanding of the individual. All of the team members will also need to keep up to date on changes in the benefit, entitlement, and health care delivery systems and they must possess skills in negotiating these multiple complex interfacing systems if they are to be effective advocates for and relevant to their clients.

At the macro level, we will need to return to the curriculums of old in which social workers were trained in community organizing and nurses, physical and occupational therapists, etc., in community health activities. We will need to learn how to move from individual problems to identification of community issues, how to develop consensus about possible solutions while taking into account the strengths and weaknesses of a community, how to identify and engage its natural and not so natural leaders to reach the broadest group possible, and how to encourage community ownership of the process. This is not a natural role for many social workers and nurses and other team members who, these days, are skilled at providing service one hip fracture at a time.

**PROCEEDING TOWARDS CHANGE**

I have no illusions about how hard it is going to be to change how we organize, locate, and deliver services to older adults–how we build
more supportive communities that promote healthy aging and can respond to changes over time. But it is already starting to happen, often in ways that incorporate many of the principles I’ve discussed.

Residents of a retirement community in Annapolis have organized to create their own on-site support center at an annual cost of $85 per resident. Staffed by a social worker and a part-time nurse from a local health care provider, it draws heavily on the talents and skills of the residents for educational programs and other kinds of supports that, once organized, can be provided by the volunteer residents themselves.

Landlords and a social service agency in Pittsburgh banded together to develop an on-site continuum of social, health, and recreational services for the older tenants of three different apartment buildings—financed by landlord and tenant contributions and foundation support.

And here in New York, there is a range of activity occurring to develop more supportive communities that will permit seniors to age in place. The largest effort is a financial and programmatic partnership between government, housing corporations and their residents, social service and health care providers, and philanthropy to develop Naturally Occurring Retirement Community (NORC)-Supportive Service Programs.

New York State and New York City have each modified the official definition of NORCS to encourage the development of the NORC Supportive Service Program model in housing communities with a high density of older residents. Currently, there are 30 programs in the State, with 28 in New York City—12 of which have both city and state funding. Targeted to moderate and low income communities large and small, programs have been developed in public housing, high-rise developments, two-story garden apartments, moderate and low income rental complexes, and moderate and low income cooperatives. Each program, with features that reflect the unique characteristics of their communities, is built around a core set of services that includes individual casework, health care services, health management and promotion, and educational, recreational, and volunteer opportunities.

As we go forward in this endeavor, there are many examples from which to learn what works, where it works and why. The United Hospital Fund’s Aging in Place Initiative seeks to do just that. Our purpose is not only to assist in the development and growth of NORC-SSP programs in New York City but also to work with the lessons embodied in those programs, and other providers of housing, health care, and social services throughout New York City and elsewhere, to develop new, community-based models of services for
older New Yorkers. We are making progress in going beyond “one
hip fracture at a time,” and with the commitment of social workers
and the collaboration of other professionals, we can ensure that our
service system is truly responsive to the need of older people.

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